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Progress made in the implementation of the Declaration of Commitment on HIV/AIDS

Report of the Secretary-General

Summary

The present report is submitted in accordance with General Assembly resolution 58/236 of 23 December 2003, in which the Assembly requested the Secretary-General to prepare a comprehensive and analytical report on progress achieved in realizing the commitments set out in the Declaration of Commitment on HIV/AIDS adopted by the General Assembly on 27 June 2001. The report draws on a broad range of data sources, including national data on key AIDS indicators from 17 countries and territories in Africa, Asia, the Caribbean and Eastern Europe,[1] other national surveys, commissioned studies and evidence-based estimates of coverage for key AIDS interventions. It tracks the current state of the epidemic and summarizes overall progress made in realizing the commitments set out in the Declaration, with a special focus on those set out for 2005.

Despite encouraging signs that the epidemic is beginning to be contained in a small but growing number of countries, the overall epidemic continues to expand, with much of the world at risk of falling short of the targets set forth in the Declaration. Similarly, while the expansion of AIDS treatment programmes has brought fresh hope to communities and re-energized community-based prevention and care efforts, the roll out of treatment programmes has been insufficient to avoid a deepening of the impact of the epidemic on some of the world's most vulnerable households, communities and countries. AIDS-related mortality continues to erode the fragile base of human capital on which sound development depends and threatens to undermine critical social institutions in hard-hit countries. The consensus that

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AIDS is an exceptional problem that warrants an exceptional response holds forth the promise that the global response to AIDS will at last match the epidemic in its scale and complexity.

In 2006, a comprehensive report will be released using end-of-year data and with expanded information on all global and country indicators.

I. Introduction

1. Since 2001, there has been a dramatic change in global action to combat AIDS. Political commitment to the fight against AIDS, sorely lacking in the early stages of the epidemic, has markedly increased at the national, regional and global levels. In the two most populous countries in the world, leadership initiatives are having a significant impact. In China, senior political leaders have begun to speak publicly about AIDS issues, while in India, the national AIDS Council — chaired by the Prime Minister — has been established, with the representation of various sectoral ministries. The response to AIDS in the Caribbean is being transformed by the leadership and collaboration of the region's political leaders, under the umbrella of the Pan Caribbean Partnership Against HIV/AIDS. The countries of Europe have pledged to ensure universal access to treatment and care by 2005 throughout Europe and Central Asia. In East Africa, early and visible political leadership is beginning to bear fruit by way of encouraging signs of early declines in HIV prevalence. In several countries in Latin America, AIDS mortality has declined since the expansion of antiretroviral treatment programmes. Donor countries are actively exploring sustainable, innovative mechanisms to finance programmes for AIDS and international development. In all regions and countries, people living with HIV continue to lead efforts to overcome the silence surrounding AIDS and to demand effective action to address the epidemic.

2. While the intensity and reach of HIV prevention programmes remain insufficient, more countries are working to apply the lessons learned at the scale and intensity needed to have an impact on the epidemic. As prevention coverage increases, some countries are making gains in alleviating the toll of the epidemic among young people. In Cambodia, HIV prevalence among sex workers and their customers has sharply declined since 1998. In the Bahamas, an expanded approach to prevention and treatment has led to decreases in HIV prevalence and AIDS mortality over the past seven years. Financial resources available in 2005 for AIDS programmes in low- and middle-income countries will most likely be nearly six times greater than amounts spent worldwide in 2001. Access to life-preserving antiretroviral therapy in low-income settings, barely imaginable at the beginning of the current decade, is fast becoming a reality in many parts of the world. For the first time, truly comprehensive responses to AIDS, including HIV prevention and treatment, are emerging.

3. The Declaration of Commitment on HIV/AIDS (General Assembly resolution S-26/2, annex) has served as a critical mechanism for advocacy, transparency and accountability in the global fight against the epidemic. The Declaration establishes clear time-bound targets that underpin the Millennium Development Goals, especially Goal 6, "To have, by 2015, halted, and begun to reverse the spread of HIV/AIDS ..."[2] Civil society is playing an increasingly valuable role in monitoring the fulfilment of these commitments.

4. Notwithstanding these and other advances in the global fight, the epidemic continues to expand. Compared to previous years, there were more new infections (4.9 million) and more AIDS deaths (3.1 million) in 2004. More than 8,000 people die every day from AIDS-related conditions. As at December 2004, an estimated 39.4 million people were living with HIV. Women now account for just under one half of all people living with HIV. This increasing feminization of the epidemic reflects the paradoxical situation facing women and girls: they face heightened

vulnerability to HIV infection, despite being less likely to engage in high-risk behaviour than their male partners. In addition, the epidemic continues disproportionately to affect adolescents and young adults with one half of the new infections occurring among this age group. An estimated 2.3 million children under 15 years of age are living with HIV, the vast majority of them infants who contracted HIV during gestation or delivery or as a result of breastfeeding.

5. The impact on children is staggering. Globally, AIDS now accounts for 3 per cent of deaths in children under 5 years of age, but in hard-hit countries, this figure may be as high as 50 per cent. Fifteen million children have been orphaned by AIDS and the number is expected to increase sharply in coming years. Millions of other children are living in households in which an adult is sick.

6. Worldwide, 1 in every 90 adults (ages 15-49 years) in low- and middle-income countries is living with HIV, representing 95 per cent of the world's HIV infections. Sub-Saharan Africa remains the hardest-hit region, accounting for 64 per cent of the world's HIV infections and for 74 per cent of all AIDS deaths in 2004. The apparent stabilization of the epidemic in some African countries is, however, occurring at an unacceptably high level and signifies that the number of AIDS deaths is now being matched by a comparable number of new infections. The epidemic has yet to display a natural saturation point. In Swaziland, the country most affected, adult prevalence continues to climb, with 42.6 per cent of pregnant women testing HIV-positive in 2004.

7. Outside Africa, HIV prevalence is highest in the Caribbean (2.3 per cent). As at December 2004, an estimated 7.1 million people in South and South-East Asia were living with HIV, including 890,000 who became infected in that year. At the end of 2004, there were nine times more people living with HIV in Eastern Europe and Central Asia than 10 years earlier. In Latin America, more than 1.7 million people are living with HIV. In 2004, the epidemic expanded in every region, including North America and Western Europe, where early prevention successes have given way in recent years to increases in sexual risk behaviour. In all regions, the epidemic disproportionately targets the most marginalized populations, such as sex workers, men who have sex with men, injecting drug users, street youth and prisoners.

8. The toll of the epidemic on women and girls has significantly intensified, largely as a consequence of the low social, economic and legal status of women in many countries. Among young people (ages 15 to 24 years) in sub-Saharan Africa, there are 36 women living with HIV for every 10 HIV-infected males. Even in regions in which men are more likely to be infected than women, the number of women living with HIV is rapidly increasing: by 56 per cent in East Asia between 2002 and 2004, and by 48 per cent in Eastern Europe and Central Asia. In addition to their high vulnerability to HIV, women and girls also shoulder a disproportionate share of AIDS-related care and support burdens.

9. Despite encouraging increases in AIDS spending in recent years, it remains difficult to transform promising local projects into broad-based programmes that have sufficient coverage to influence the course of the epidemic. Owing in large measure to the failure to adopt comprehensive approaches, the rate of new HIV infections and AIDS deaths is accelerating, with especially disturbing signs of growth of the epidemic in Asia, where one half of the world's population lives.

Worsening impact of AIDS

10. Although expanding treatment programmes offer hope, it is possible that 11 countries in sub-Saharan Africa will by 2006 have lost more than one tenth of their labour force to AIDS. In what may be an early glimpse of the epidemic's long-term capacity for broad-based damage, the effect of AIDS on agricultural sectors played a pivotal role in the recent food crisis in Southern Africa. The consequences of the epidemic are not confined to Africa: studies by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Asian Development Bank estimate that AIDS will slow the rate of poverty reduction in Cambodia by an average of 60 per cent between 2003 and 2015.

11. The most damaging aspect of the epidemic may be its tendency to sever the generational ties on which societies depend for the transmission of values, cultural norms and practical know-how. By targeting young, working-age adults, AIDS unleashes a chain of events that threatens to cause entire societies to unravel. In short, AIDS is an exceptional problem which demands an exceptional response.

II. Key findings

12. Reaching the targets set out in the Declaration of Commitment and the Millennium Development Goals requires a comprehensive response in both scope and coverage. Unknown to the world less than 25 years ago, AIDS represents a unique threat to international development, which undermines the hope of achieving the Millennium Development Goals.

Rate of new infections

13. **Many of the most affected countries are at risk of falling short of the target of reducing by 2005 the level of infection in young men and women aged 15 to 24.** While some countries are experiencing a degree of success in reducing infection levels in certain populations, the pace of the epidemic's expansion throughout the world is accelerating. Although proven strategies exist to prevent new HIV infections, essential prevention strategies reach only a fraction of those who need them. Delivery of life-saving prevention services is especially vital for young people, who represent one half of all new infections, and for marginalized and vulnerable populations.

Expanding access to treatment

14. **While the number of people on antiretroviral therapy increased by nearly two thirds during the second half of 2004, in low- and middle-income countries only 12 per cent of those who need antiretroviral therapy were receiving it as at December 2004.** The "3 by 5" campaign,[3] launched by the World Health Organization (WHO) and UNAIDS in December 2003, has galvanized substantially stronger commitment to scaling up access to treatment. Treatment — once considered unfeasible in settings in which resources are limited — now presents an unprecedented opportunity to develop comprehensive national responses to

HIV/AIDS in which care and prevention and impact mitigation efforts are delivered in a comprehensive and mutually reinforcing manner.

Human rights and AIDS

15. **While many surveys of national AIDS responses and policies reveal the existence of human rights safeguards, such measures frequently lack the specificity and enforcement mechanisms necessary to combat the associated stigma and gender-based discrimination.** Many countries have yet to adopt legislation that will prevent discrimination against people living with HIV, and even fewer have enacted measures to promote and protect the human rights of vulnerable populations.

Orphans and children made vulnerable by HIV/AIDS

16. **Most high-prevalence countries are making considerable efforts to protect children orphaned or made vulnerable by the epidemic but available evidence indicates that national efforts and the level of donor support are currently not sufficient to address this growing crisis.**

Building sustainable capacity

17. **A major barrier to the implementation and expansion of essential AIDS programmes is the acute shortage of trained personnel who possess requisite skills and expertise.** The strategies exist to preserve and build national capacity, including maximizing use of community resources, but donors and recipient countries have often failed to integrate such approaches into programmatic efforts.

Increasing but still inadequate financial resources

18. **If current spending trends continue, by 2007 there will be a significant shortfall between the funds available and the resources needed to finance a response that is comprehensive in both scope and coverage.** Further details are provided in section VII below. The impact of resources at the country level will be maximized by strong national ownership of the response, the harmonization of efforts and the establishment of appropriate institutional and administrative frameworks, objectives that underpin the "Three Ones" initiative,[4] which has been embraced by diverse stakeholders throughout the world.

III. Prevention

19. The Declaration of Commitment identifies HIV prevention as the mainstay of the AIDS response, reflecting the global commitment to implementing comprehensive, evidence-based programmes for the prevention of new infections. The pace of new infections is accelerating, and expanded coverage of prevention programmes is imperative. Effective prevention is especially critical to sustaining global efforts to expand access to treatment in resource-limited settings. Similarly,

the expansion of treatment and care will reinforce the effectiveness and scope of prevention interventions.

20. In accordance with the Declaration, 90 per cent of young people aged 15 to 24 should have access by 2005 to the information, education and services needed to protect themselves from infection. By the end of 2005, HIV prevalence among young men and women (ages 15 to 24) in the most affected countries should be 25 per cent lower than in 2001, and the proportion of infants infected with HIV should have fallen by 20 per cent. The Declaration also envisaged a significant strengthening of the HIV/AIDS response in the world of work, the implementation of strategies to prevent HIV transmission among migrants and mobile workers, and the adoption of a broad range of initiatives to reduce the vulnerability of young people and other highly vulnerable populations.

21. Much more is known today on how to prevent HIV transmission. Effective HIV prevention incorporates a combination of approaches, including the provision of life-saving information, promotion of abstinence and fidelity, forging of new social norms, building of the skills and motivation of individuals to protect themselves from infection, and creation of the social and physical environments that encourage risk reduction. Strong prevention programmes also combat the stigma associated with AIDS and work to reduce the root causes of heightened vulnerability to infection. Interventions that deviate from this comprehensive model by placing undue emphasis on certain strategies to the exclusion of others, remain largely unproven. In all countries that have reversed the spread of national epidemics, prevention programmes have benefited from the vocal and sustained support of national political leaders.

22. Worldwide, the number of people receiving counselling and testing services has doubled since 2001, the number of women offered services to prevent mother-to-child transmission has increased by 70 per cent, and the number of young people who have received AIDS education has doubled.

23. Such encouraging trends, unfortunately, represent the exception rather than the rule. Most countries have yet to embark on a concerted effort to address the factors that increase vulnerability to infection. Even for programmes targeted at the most vulnerable or those supporting interventions with long-standing evidence of effectiveness, coverage is minimal. Worldwide, targeted prevention services in 2003 reached only 16 per cent of sex workers, 11 per cent of men who have sex with men, 53 per cent of prisoners, 20 per cent of street children and less than 5 per cent of the world's 13.2 million injecting drug users. Less than 0.4 per cent of adults in low- and middle-income countries received voluntary counselling and testing services in 2003. Relatively little has been invested in evidence-based initiatives to prevent young people from using drugs or in services that help individuals to recover from drug use.

24. Globally, services to prevent mother-to-child transmission reach only 8 per cent of pregnant women, including just 5 per cent of pregnant women in Africa which has cumulatively accounted for 90 per cent of all children born with HIV. Global efforts to reduce the number of infants born with HIV infection continue to suffer from the limited access of women to primary HIV prevention and health services. Promoting women's access to antiretroviral therapy for their own health — and providing food, nutritional services and other basic benefits — can help to

increase their participation in services to prevent mother-to-child HIV transmission and improve medical outcomes for both mothers and newborn.

25. In recent years, progress has been made in regard to the implementation of a comprehensive response to AIDS in the world of work as a growing number of stakeholders embrace the International Labour Organization Code of Practice on HIV/AIDS and the World of Work.[5] The proportion of firms in high-prevalence countries that have adopted HIV/AIDS policies has increased by 75 per cent in the past year. The Global Business Coalition has encouraged business leaders to influence change at the global policy level and to address stigma among workers. The International Organisation of Employers and the International Confederation of Free Trade Unions have taken action, separately and together, to strengthen the workplace response, including the issuance of a joint pledge of collaborative and intensified action to combat AIDS.

26. Stronger efforts are required to achieve the goal of ensuring comprehensive prevention services for mobile populations. In 2003, less than one half of countries had strategies in place to promote HIV prevention for cross-border migrants but efforts are under way to address AIDS among mobile populations. In India, where a recent survey found that 16 per cent of truck drivers working a route in the southern part of the country were HIV-positive, the Avahan AIDS initiative is implementing HIV prevention programmes at 50 key truck stops. The World Food Programme is working to ensure that its contracted food transporters receive comprehensive HIV prevention services.

27. Many Governments have failed to prioritize prevention initiatives that target the populations at greatest risk of infection, which remain stigmatized. A 2004 survey of national AIDS spending in 26 countries found that some countries preferred to direct their limited prevention resources towards less effective initiatives that focus on the general population and people at low risk. This approach misses the critical opportunity to prevent an epidemic that is concentrated in the most vulnerable populations from spreading to the population at large.

Capitalizing on increased access to treatment in order to strengthen HIV prevention

28. Increased access to treatment offers a unique opportunity to strengthen HIV prevention efforts. Access to antiretroviral therapy increases the incentive to be tested for HIV, helps to reduce the stigma associated with AIDS and attracts individuals to health-care settings in which prevention messages can be delivered and reinforced. To capitalize on these opportunities, national programmes and donors should emphasize the delivery of prevention services in clinical settings, the creation of community-based prevention programmes delivered by and for people living with HIV (incorporating, where feasible and appropriate, the delivery of other essential services, such as nutritional support) and the adoption of treatment literacy initiatives to promote broad community understanding of the benefits and limitations of the available therapies.

Promoting effective prevention for women, girls and young people

29. Substantially stronger efforts are required to combat the increasing burden that the epidemic places on women and girls. Not only are women three to four times more physiologically susceptible than men to infection during sexual intercourse, they also confront a host of economic, social and legal factors that increase their vulnerability to infection, as discussed in paragraphs 56 to 61 below.

30. Increasing the access of women, girls and their sexual partners to timely, high-quality health services represents an important prevention priority. Such services can enhance women's access to information and education, address barriers to condom use and other forms of risk reduction, promote women's knowledge of their HIV status, facilitate the effective management of sexually transmitted diseases and serve as a gateway to services to prevent mother-to-child transmission of HIV. In 2004, the United Nations Population Fund spearheaded the development and broad endorsement of the New York Call to Commitment, which articulates a comprehensive framework to maximize the use of sexual and reproductive health services to strengthen the global AIDS response.

31. Achievement of the prevention targets set out in the Declaration will require greater success in reaching young people with essential information, education and services. Although knowledge levels among young people have improved, more than one half of those surveyed in nine countries in sub-Saharan Africa lacked comprehensive information about HIV prevention. In Indonesia, 6 per cent of young men (ages 15 to 24) reported using a condom the first time they had sex, and less than one in six reported having used a condom during their most recent episode of sexual intercourse or when they most recently patronized a sex worker. Although an enormous body of data highlights effective strategies to reduce risk behaviour among young people, surveys consistently find that most of the world's young people lack meaningful access to youth-oriented prevention services.

Reducing the contribution of injecting drug abuse to new HIV infections

32. To wage a comprehensive fight against new HIV infections, there must be significantly increased access to programmes that address the role of injecting drug use in facilitating the spread of HIV. Key services include prevention of drug abuse, drug-dependent treatment (including substitution maintenance therapy) and access to sterile injection equipment. The obligation to eradicate illegal drug use among prisoners must be balanced against their right to health care, including measures proven to prevent the transmission of disease through drug use. To help build national capacity to curb the contribution of drug use to the epidemic, the United Nations Office on Drugs and Crime is currently implementing technical assistance projects in a number of regions.

Developing new prevention tools

33. New prevention approaches are badly needed to buttress existing proven tools, especially those for women and girls who typically lack prevention strategies that they can independently control. Five microbicide candidates are now being tested in

large-scale human clinical trials, By promoting collaboration among researchers, the multi-stakeholder Global HIV Vaccine Enterprise seeks to bring renewed energy to the global search for a HIV vaccine. To expedite the initiation of clinical trials and accelerate the future introduction of new prevention technologies that prove to be effective, the European Union in 2004 approved new policies to assist developing countries, upon request, to undertake technical scientific reviews of new products intended primarily for use in developing countries.

Recommendations

34. **The following action is recommended in regard to HIV prevention:**

(a) **Scale up successful and proven prevention activities under the leadership of national authorities and with the collaboration of all stakeholders;**

(b) **Target prevention efforts to achieve maximum impact, especially in countries in which epidemics are concentrated among highly vulnerable populations;**

(c) **Ensure that, with the scaling up of treatment services, every opportunity is taken to enhance prevention;**

(d) **Increase the provision of prevention education and support for young people (both those who are in and out of school) and implement policies that address the heightened vulnerability of women and girls;**

(e) **Strengthen prevention activities in the world of work and initiatives that address migrant populations.**

IV. Treatment, care and support

35. The Declaration of Commitment recognizes AIDS treatment, care and support as fundamental elements of the global response. It provides that countries will develop and make significant progress in implementing comprehensive care strategies and in strengthening health systems in order to increase access to affordable medicines, diagnostics and related technologies, and to deliver the highest available standard of AIDS care, including antiretroviral therapy.

36. Since 2001, a strong consensus has emerged that providing treatment and care to people living with AIDS is a humanitarian and ethical imperative, resulting in the launch of the 3 by 5 initiative[3] by WHO and UNAIDS. This push to expand dramatically the availability of treatment has gained impetus through the convergence of several factors, including renewed political will and leadership, rapidly falling drug prices and the availability of financing. Achieving this goal and universal access in future years will require standardized treatment regimens, new training methods, the use of community health workers and more effective drug supply systems. Such approaches provide significant new opportunities to expand the scope of prevention interventions and to consolidate and strengthen ailing public health systems.

Expansion of access to treatment

37. All major donors recognize that AIDS programmes must comprehensively address prevention, treatment, care and support. More than 40 countries have developed a national treatment scale-up plan and over 30 countries have set ambitious treatment targets in line with the 3 by 5 initiative. As a result, access to antiretroviral therapy has increased significantly in all regions over the past two years, even in countries in which resources are severely limited. In low- and middle-income countries, the number of individuals receiving antiretroviral therapy increased from an estimated 400,000 in June 2004 to 700,000 by December 2004. In sub-Saharan Africa, utilization of antiretroviral therapy more than doubled in the second half of 2004 and the number of service delivery points greatly expanded. The number of people receiving treatment in Botswana, Kenya, South Africa, Uganda and Zambia increased by more than 10,000 in each country over a six-month period. Botswana, Namibia and Uganda now provide antiretroviral therapy to more than one quarter of those who need it. Antiretroviral therapy coverage exceeds 50 per cent in seven countries in Latin America. In Asia, Thailand is initiating antiretroviral therapy for an additional 3,000 individuals each month, while access to antiretroviral therapy in Cambodia has increased tenfold since 2003.

38. In countries in which access to antiretroviral therapy is expanding, people with AIDS and their families are being rejuvenated. The survival rates of patients on antiretroviral therapy in low- and middle-income countries are 90 per cent one year after initiating treatment and approximately 80 per cent after two years. Brazil has reduced the AIDS mortality rate by approximately 80 per cent since 1996 by providing extensive access to antiretroviral therapy through the public sector. In high-income countries, in which access to antiretroviral therapy ranges from 70 per cent to more than 90 per cent, dramatic reductions in AIDS mortality and in the number of infants born with HIV have occurred.

39. The benefits of treatment extend beyond individuals and households, affecting society as a whole. In one South African township, for example, the number of local AIDS support groups has more than doubled since the introduction of treatment. The availability of AIDS treatment has increased AIDS awareness in the community, stimulated demand for HIV testing and helped to ease the stigmatization of people living with HIV.

> Despite having the lowest per capita income in the Western Hemisphere, Haiti, with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, is making important strides in expanding access to antiretroviral therapy. By December 2004, tens of thousands of individuals had been counselled and tested, and 2,000 people in urban and central Haiti had been placed on antiretroviral therapy.

40. National plans to increase access to treatment have been assisted by the promulgation by WHO of antiretroviral therapy guidelines for resource-limited settings, the pre-qualification of antiretroviral therapy drugs, increased levels of technical support and its coordination of the AIDS Medicines and Diagnostic

Service, which provides support for the procurement and management of AIDS drugs and diagnostics.

41. The $15 billion President's Emergency Plan for AIDS Relief of the United States of America is providing significant new resources to national AIDS programmes, including access to treatment. As at January 2005, the Global Fund to Fight AIDS, Tuberculosis and Malaria had approved funding that will ultimately support the delivery of antiretroviral therapy to an estimated 1.6 million people in resource-limited settings. The World Bank has also increased its support for antiretroviral therapy. The mobilization of the business sector and public-private partnerships is helping to provide comprehensive care and support.

Obstacles to accessing AIDS care and treatment

42. As many as 100,000 health and community workers must be trained to expand access to antiretroviral therapy throughout the world, an effort that is being supported through the adoption of innovative approaches, such as the WHO Integrated Management of Adult and Adolescent Illness modules. To facilitate early diagnosis, several countries have implemented policies which promote the routine offer of confidential HIV counselling and testing services.

43. While prices for antiretroviral treatment have substantially declined, the average annual $300 price tag for first-line antiretroviral regimens still inhibits broader access. Achieving and sustaining broad access to antiretroviral therapy will require further declines in the prices of both first- and second-line treatments and of diagnostic and monitoring technology, which remains prohibitively expensive in many parts of the world.

44. Although 15 per cent of those infected are children, less than 5 per cent of those on treatment are children. Diagnostic tests to identify HIV infection in children aged under 18 months are expensive, and paediatric formulations of antiretroviral drugs are scarce and more costly than adult medications.

45. To ensure that the benefits of currently available regimens are maximized, global efforts to minimize the development of drug resistance are important. Efforts include the sentinel surveillance of HIV drug resistance, the use of simplified regimens and fixed-dose combinations, and the provision of support in regard to patient education, counselling and adherence. Patient adherence and programme sustainability will also be supported through equitable and innovative approaches to financing that do not depend upon user fees at the point of service delivery.

Recommendations

46. **The following action is recommended in regard to treatment, care and support:**

(a) **Review national testing policies in order to encourage more widespread knowledge of serostatus, and increase donor financial support for testing initiatives;**

(b) **Take global action to lower further the price and accessibility of first- and second-line antiretroviral therapy regimens, including the current high-priced and often unavailable antiretroviral therapy regimens for children;**

(c) **With the assistance of donors and technical agencies, strengthen systems to monitor equitable access to treatment for women, girls and vulnerable populations, including through the provision of disaggregated data by sex;**

(d) **Integrate HIV prevention, home-based care, psychosocial services, treatment support, treatment of opportunistic infections and food and nutritional support with antiretroviral therapy as components of comprehensive AIDS care;**

(e) **Maximize the use of community workers and paraprofessionals in delivering and/or monitoring antiretroviral therapy and in promoting treatment adherence in order to accelerate the scaling up of treatment services.**

V. Orphans and children made vulnerable by HIV/AIDS

47. In accordance with the Declaration of Commitment, by 2005 countries are required to implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans[6] and girls and boys infected and affected by HIV/AIDS. This includes the provision of counselling and psychosocial support, and ensuring their access to education, health support, shelter and nutrition on an equal basis with other children. The Declaration also provides that countries will take steps to protect orphans and vulnerable children from abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.

48. Globally, 15 million children have been orphaned by AIDS, a number expected to increase sharply in the coming years. AIDS is primarily responsible for the dramatic growth in the number of orphans in sub-Saharan Africa, which increased by more than one third between 1990 and 2003. Twelve million children in Africa have lost one or both parents to the disease, while millions live in households in which an adult is sick.

Strengthening families and communities

49. The United Nations Children's Fund has spearheaded the development of the comprehensive *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*[7] which identifies tools to guide national action. Priority programmatic responses to protect children include access to antiretroviral therapy in order to keep one or both parents alive and healthy, initiatives to enhance the food and economic security of AIDS-affected families and community-based vocational education initiatives for affected children.

50 Data on school attendance suggest that many countries are making progress in preserving the educational opportunities of children affected by AIDS. While school attendance has historically been much lower for orphans than for non-orphaned children, household surveys undertaken between 2001 and 2003 in nine African

countries indicate that the rate of attendance of orphans now approaches parity with non-orphans. Ensuring access to education is paramount, underscoring the potential of universal education programmes, the elimination of school fees, and the provision of in-school meals to alleviate the long-term impact of the epidemic on young people.

51. Other effective efforts include the adoption of policy and legislative initiatives to protect children from harm and abuse, ensuring the access of children to essential services, action to raise public awareness and mobilize broad-based action by society at large, and the implementation of programmes to address the nutritional needs of households and communities. These and other strategies aim to strengthen the capacity of families to protect and care for AIDS-affected children. A 2004 survey of countries in sub-Saharan Africa indicates that one third have enacted laws to support orphans and to protect them from abuse. However, only one country indicated that it possessed sufficient resources fully to enforce those laws.

> Rwanda, home to an estimated 160,000 children orphaned by AIDS, is making significant strides in addressing the impact of the epidemic on orphans and children made vulnerable by HIV and AIDS and was among the first to enact comprehensive child-focused policies.

Recommendations

52. **The following recommendations are made in regard to orphans and children made vulnerable by HIV/AIDS:**

(a) **Implement the Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS by taking urgent steps to develop and operationalize action plans for each of the key tools of the Framework;**

(b) **Accelerate efforts to abolish school fees, increase the coverage of school meal programmes and remove other barriers for orphans and children made vulnerable by HIV and AIDS;**

(c) **Establish and monitor national treatment targets for HIV-infected children.**

VI. Human rights and gender equality

53. Discrimination, stigma and gender inequalities continue to fuel the spread of HIV. The Declaration of Commitment recognizes that the realization of human rights and fundamental freedoms for all is essential to reducing vulnerability to infection. In accordance with the Declaration, all countries should have in place, and enforce meaningful protections against, HIV-based discrimination and prohibit discrimination against populations vulnerable to HIV infection. The Declaration also calls for, by 2005, the development and accelerated implementation of national strategies for women's empowerment, the advancement of women and the promotion and protection of their full enjoyment of all human rights, and the

implementation of measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection.

Ensuring the full participation of people living with HIV

54. In all countries that have reversed their national epidemics, a common element of the national response has been a strong commitment to human rights and non-discrimination and the active engagement of people living with HIV. Unfortunately, in many countries, the stigma associated with AIDS perpetuates a climate of silence and denial that discourages people living with HIV from disclosing their status, especially in the workplace. Nearly one half of countries in sub-Saharan Africa, and nearly 40 per cent worldwide, had by 2003 yet to adopt legislation to prevent discrimination against persons living with HIV and AIDS. Even fewer countries have enacted laws to protect vulnerable populations from discrimination, including displaced populations and refugees.

55. Violations of rights hamper access to prevention, treatment and support services for the marginalized groups that are particularly vulnerable to infection, including injecting drug users, sex workers and men who have sex with men. Displaced populations, in particular women and children affected by conflict, emergencies or trafficking, confront extraordinary stigma and often face sexual violence, exploitation and separation from support services. The Office of the United Nations High Commissioner for Refugees, which became a UNAIDS co-sponsor in 2004, has significantly increased its capacity to identify, report and respond to HIV-related human rights violations against refugees or other displaced people.

Growing vulnerability of women

56. Notwithstanding their low-risk behaviour, women and girls are increasingly vulnerable to HIV infection as a result of their low status and their profound economic dependence on men. Surveys of young people in sub-Saharan Africa have consistently found that young women are less likely than young men to have comprehensive knowledge of HIV prevention, indicative of the limited educational opportunities for girls.

57. In many countries, married women have insufficiently recognized property or inheritance rights. Upon divorce or a husband's death, women are often left destitute, frequently with children for whom they must care. Lacking economic independence and an equal say in relationships, women and girls are often powerless to protect themselves from HIV infection because the tools at their disposal — faithfulness, male condoms and abstinence — typically require the cooperation of their male sexual partners.

58. Even in stable relationships, women may be at risk owing to their partner's HIV serostatus and the engagement of the latter in high-risk behaviour outside marriage. For example, while married women who marry young are less likely than their non-married counterparts to have multiple partners, studies in Kenya and Zambia indicate that married men are roughly three times more likely to be infected with HIV than the young partners of single young women.

59. Another extreme manifestation of gender inequality is violence against women. Between 30 and 60 per cent of women surveyed in 10 countries in Africa, Asia and the Pacific, South America and Europe report having experienced physical or sexual violence involving an intimate partner. Between 20 and 48 per cent of girls and young women aged 10 to 25 years, report that their first experience was coerced. This coercion increases women's risk of contracting HIV and their fear of negotiating the use of condoms.

60. With few economic options, women and girls are sometimes obliged to engage in transactional sex as a means of livelihood for themselves and their families. In many parts of the world, human trafficking networks force thousands of women and girls into sex work.

61. Women and girls also bear a disproportionate share of the burden of care for infected family members. A survey of three South African provinces found that almost three quarters of AIDS-affected households were headed by females, a significant proportion of whom were themselves battling AIDS-related illnesses. This burden of care is further aggravated by poverty, hunger and weak public services, with far-reaching health, social and economic consequences for women and girls. Women also bear a large burden in caring for orphaned children.

> Botswana has enacted legislation to enhance the status of women and girls (e.g., the Abolition of Marital Power Bill) giving married women an equal say in the disposal of family assets. A comprehensive system is also being developed to keep girls in school, reduce teenage pregnancy and integrate young mothers back into school following delivery.

Forging new cultural norms

62. The long-term fight to curb the spread of HIV also requires changes in the attitudes of men and boys, which can best occur if children are appropriately socialized at an early age. To implement such profound changes in cultural norms, unprecedented advocacy is needed. Since its formation in 2004, the Global Coalition on Women and AIDS has united diverse stakeholders in a common advocacy agenda to increase awareness of the impact of the epidemic on women and girls and to harness support for new cultural norms. Courageous advocates for gender equality are working in countries throughout the world, and their efforts merit strong financial and political support.

Recommendations

63. **The following action is recommended in regard to human rights and gender equality:**

(a) **Enact and implement meaningful laws to prohibit discrimination against people living with HIV/AIDS and marginalized and displaced populations, and put in place and aggressively pursue enforcement mechanisms;**

(b) **Strengthen gender equality initiatives, take immediate steps to raise the status of women and girls, including by providing them with income-generating opportunities, and actively promote new social norms among men and boys;**

(c) **Enact national laws to ensure gender equality in property and inheritance rights;**

(d) **Undertake efforts to increase women's knowledge of their legal rights, combat violence against women and strengthen efforts to eradicate trafficking;**

(e) **Promote universal free education for girls and boys and school-based meal programmes.**

VII. Resources

64. On the basis of the evidence available in 2001, the Declaration of the Commitment called for the mobilization of annual expenditures of between $7 billion and $10 billion by 2005 for essential programmes in low- and middle-income countries and those countries experiencing or at risk of experiencing rapid expansion of the HIV/AIDS epidemic. Since then, the resources available from all sources, including national spending in low- and middle-income countries, have dramatically increased. It is estimated that $6.1 billion were available in 2004 to implement comprehensive programmes in 135 low- and middle-income countries, representing a 23 per cent increase over the estimated expenditures in 2003 and an increase of 20 times the amounts spent in 1996. Based on current trends and funding commitments, UNAIDS projects that the resources available to these countries will be close to $8 billion in 2005 and $10 billion by 2007, with the latter comprising $3 billion from domestic sources, $6.7 billion from international assistance and $364 million from foundations and non-governmental organizations.

65. National spending assessments indicate that affected countries have also substantially increased their AIDS-related expenditures through increased public allocations and higher out-of-pocket expenditure. Domestic spending on AIDS in 2007 is projected to be at least 20 per cent higher than in 2004, mainly owing to increased public expenditure in treatment and care, thereby offering some respite from the catastrophic out-of-pocket expenses that many individuals have borne thus far. Low- and middle-income countries, however, continue to lack the financial means to close the AIDS resource gap.

66. Donor countries have increased their bilateral and multilateral contributions for HIV/AIDS. It is estimated that bilateral resources available for AIDS may increase from $1.3 billion in 2004 to $2.3 billion in 2005, reaching an estimated $3.65 billion in 2007. Donor countries have also channelled additional resources through multilateral organizations, whose AIDS-related funding doubled from $1.5 billion to $3 billion between 2003 and 2005. Of particular note, the Global Fund to Fight AIDS, Tuberculosis and Malaria has committed more than $1.7 billion in additional resources for AIDS.

67. Although efforts to mobilize the resources called for in the Declaration appear to be on track, additional data-driven analyses undertaken since 2001 indicate that significantly increased resources will be required in future years to generate a

comprehensive response. In particular, financial investments and extensive technical support will be needed to enable resource-constrained countries to programme effectively the increased level of resources now being made available. If sufficient resources are to be mobilized to bring essential programmes to scale, initial projections by UNAIDS indicate that additional resources will be needed, with the bulk from the international community. Multiple studies are currently under way further to refine estimates and to develop a consensus on the global financial needs that will ensure a comprehensive response. It is expected that the revised estimates will be available by mid-2005.

Three Ones: making the money work

68. The quality of aid is just as important as the quantity. The likelihood that the gap between available and needed resources will grow underscores the importance of using the available resources as effectively as possible. Historically, the limited national capacity of many countries has been further sapped by the multiplicity of the funding requirements of the various donors, which also have often failed to ensure that their individual programmes support national strategic AIDS goals.

69. National leaders, donors and multilateral agencies have reached consensus over the past two years on a single strategy, known as the Three Ones,[4] for planning and monitoring activities at the country level, with the goals of optimizing coordination and reducing duplication of effort. A major priority in the near term will be to promote the adherence of all stakeholders to the Three Ones approach.

Building sustainable capacity

70. The effectiveness of future increases in spending for AIDS will depend in large part on the capacity of recipient countries to make effective use of such resources. In addition to the estimates of financial resources needed annually to finance a comprehensive programme, accompanying investments in capacity are essential for maximizing the effectiveness of available funds.

71. Many of the most affected countries also face a severe human resources crisis in health sectors, educational systems, public administration and private firms. Various countries are pursuing innovative strategies to strengthen the workforce, although donor support for such initiatives is presently inadequate. The United Nations Educational, Scientific and Cultural Organization is presently developing a global initiative on HIV/AIDS and education to mobilize greater support and additional resources for measures to preserve, build and sustain national capacity in educational sectors. The Southern Africa Capacity Initiative of the United Nations Development Programme seeks to assist countries in arresting the capacity erosion caused by AIDS and in advancing their development objectives.

72. In many countries, health sectors are currently too weak to provide the services that will be required by the scaling-up of the AIDS response, in particular as regards antiretroviral treatment. Reasons include lack of investment in health infrastructure, insufficient numbers of health professionals, and a reluctance by donors to finance operational costs, especially salaries.

73. Similar infrastructural weaknesses and constraints in capacity impede national efforts to monitor the epidemic, prevent new infections and support orphans and children made vulnerable by AIDS. The urgent human resources crisis requires unblocking the systemic barriers to developing stronger capacity in the health and other sectors, stemming the drain of skilled manpower from the public service into non-governmental organizations and the private sector and from the poor to the richer countries, and reducing the urban-rural bias in the provision of services.

74. Solutions to these problems include maximizing the use of community-based resources, expanding training programmes for professionals and paraprofessionals and, where appropriate, short-term deployment of trained staff from other countries. Adequate modes and levels of the involvement of ministries of finance, of planning, and civil service/public sector reforms must be identified and ensured.

75. During the Consultation on Human Resources for Health held in Oslo in February 2005, recommendations were made to develop a global action platform which could lead to more coherent and evidence-based policies and advocacy, especially as regards resource mobilization. In particular, there is a need to ensure that human resources are adequately incorporated as a major part of health sector planning.

> In response to the virtual absence prior to 2003 of antiretroviral treatment training programmes in Central and Eastern Europe, the German foundation Gesellschaft für Technische Zusammenarbeit underwrote an international project to create a regional HIV knowledge hub in Ukraine, which was launched in 2004. With financial support from the Global Fund and the International HIV/AIDS Alliance, the knowledge hub in its first year trained 66 caregivers.

Spending on AIDS research

76. The International AIDS Vaccine Initiative estimates that between $624 million and $670 million was spent on AIDS vaccine in 2002, with the public sector accounting for 67 per cent of the expenditure. In 2004, an estimated $143 million was spent worldwide on microbicide, with the United States representing the single largest source of funding. Collaboration is under way to refine the estimates of future resource needs in this area.

Recommendations

77. **The following recommendations are made in regard to resources:**

(a) **Mobilize the financial resources needed from the international community to urgently provide full funding for an expanded, comprehensive response to the epidemic, based on the needs identified by UNAIDS and partners, including full funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria as one of the major channels for financing this global effort;**

(b) **Narrow the expected shortfalls by securing the commitment of national leaders of low- and middle-income countries to increase, where possible, allocations to AIDS from domestic budgets;**

(c) **Develop and finance short- and long-term plans to build sustainable national capacity to mount a high-level response to the epidemic, as well as basic operating costs and infrastructural development;**

(d) **Simplify and further harmonize support to national AIDS responses in order to increase the impact on the AIDS epidemic and reduce the burden placed on the managerial and technical capacity of countries, and promote national ownership of the AIDS response by implementing the principles set forth in the Three Ones initiative;**

(e) **Strengthen reporting on the effectiveness of AIDS funding and programme implementation in order to ensure that policies and practices respond to and anticipate the evolving challenges of the AIDS epidemic.**

VIII. Monitoring and evaluation

78. Over the past two years, important steps have been taken to strengthen monitoring and evaluation efforts at the global and country levels. The UNAIDS secretariat and co-sponsors, together with the Global Fund, have refined indicators to measure the implementation of the Declaration, conducted or commissioned numerous surveys to gauge national responses, and provided extensive technical support to improve national information systems. They are also better able to estimate coverage for key interventions and to identify target coverage levels for specific interventions in different epidemic settings. Global capacity to monitor the flow of donor contributions has significantly improved over the past two years, as has the ability to estimate the total resources available for AIDS programmes in low- and middle-income countries. National epidemiological surveillance systems are also stronger, increasing the reliability of global, regional and country-level estimates regarding the epidemic.

79. Nevertheless, monitoring and evaluation efforts continue to suffer from important weaknesses that diminish the world's ability to detect, and rapidly respond to, emerging AIDS trends and issues. Owing in part to the difficulty of analysing AIDS-related expenditure by many donors, one cannot reliably categorize how the resources available in most countries are being spent (i.e., on prevention, treatment and care, orphan support etc.). Similarly, although ensuring equitable access to key services for women, girls, orphans and other children, young people and vulnerable populations is near the top of the global AIDS agenda, current monitoring and evaluation systems have little, if any, ability to disaggregate service utilization according to gender, age or social grouping.

Recommendations

80. **The following action is recommended in regard to monitoring and evaluation:**

(a) **Strengthen efforts to achieve a core national monitoring and evaluation system that provides high-quality data for analysing country performance in relation to the national AIDS action framework;**

(b) Increase investment in building monitoring and evaluation capacity at the global, regional and national levels;

(c) Disaggregate the service utilization data of monitoring and evaluation programmes by age, gender and social grouping in order to monitor and assess the equity and effectiveness of national investments in AIDS programmes;

(d) Categorize AIDS spending data according to funded activities, including prevention, treatment and care and orphan support.

IX. Conclusions

81. **While political commitment to the AIDS response has become significantly stronger since 2001, it remains inadequate in many countries in which the epidemic is emerging as a major problem. Strong and energetic leadership is especially vital in all countries in Asia and Eastern Europe, where the opportunity to prevent the epidemic from becoming generalized is quickly vanishing. Leadership is similarly critical in high-income countries in order to reinvigorate their prevention efforts and to close the gap between the available resources and those needed for the global fight against AIDS.**

82. **In 2006, the General Assembly will receive a comprehensive report on international progress in implementing the Declaration of Commitment on HIV/AIDS, with special reference to the targets set for 2005. The approach of this important milestone in the global response should motivate leaders from all walks of life, especially political leaders, to redouble their efforts to contribute to an effective response. As the impact of the epidemic on our world becomes increasingly apparent, failure in our response to AIDS is a possibility too disturbing to contemplate, yet one that will surely occur if effective action is not taken.**

Notes

[1] Anguilla, Barbados, Botswana, Cambodia, Côte d'Ivoire, Ethiopia, Ghana, Guinea, Indonesia, Jamaica, Montserrat, Russian Federation, Rwanda, Senegal, Trinidad and Tobago, Ukraine and Zambia.

[2] United Nations Millennium Declaration (General Assembly resolution 55/2), para. 19.

[3] To place 3 million people living with AIDS in developing countries and countries with economies in transition on antiretroviral treatment by 2005.

[4] Launched at a high-level meeting hosted by UNAIDS, the United Kingdom of Great Britain and Northern Ireland and the United States of America on 25 April 2004, the "Three Ones" principles promote: **One** agreed AIDS action framework that provides the basis for coordinating the work of all partners; **One** national AIDS coordinating authority with a broad-based multisectoral mandate; and **One** agreed country level monitoring and evaluation system.

[5] Adopted by the Governing Body of the International Labour Organization in June 2001. For the text, see *An ILO code of practice on HIV/AIDS and the world of work* (International Labour Office, Geneva, 2001).

[6] An orphan is defined as a child under 18 years of age, who has had at least one parent die.

[7] United Nations Children's Fund, New York, July 2004.